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HMO of Pennsylvania

A Case Study of an IPA in Willow Grove, Pennsylvania

HMO

U.S. Department of
Health and Human Services
Public Health Service
Office of Health Maintenance Organizations

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HMO of PENNSYLVANIA

A Case Study of an IPA
in Willow Grove, Pennsylvania

U.S. Department of Health and Human Services
Public Health Service
Office of Health Maintenance Organizations
Division of Program Promotion
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TABLE OF CONTENTS

I. INTRODUCTION.....1

II. HISTORY AND BACKGROUND.....2

III. ADMINISTRATION.....4

IV. MARKETING.....6

V. PROVIDER COMPONENT.....9

VI. FINANCE.....17

VII. CONCLUSION.....18

I. INTRODUCTION

The HMO of Pennsylvania (HMO of Pa.) is a federally qualified Individual Practice Association model Health Maintenance Organization located in Willow Grove, a suburb of Philadelphia.

The plan received federal development grant funds in order to meet the requirements of the HMO Act of 1973, as amended, and became operational in April, 1977. HMO of Pa. currently serves close to 60,000 members.

HMO of Pa. is a unique IPA because of its method of payment for the medical services provided by physicians. Membership in the IPA is limited to primary care physicians. They are paid on a capitation basis, and they must cover both their own services and specialty services from the capitation payment they receive. The capitation payment varies with the category of the patients, who are grouped into four categories, (male, female, medicare and pediatrics). The primary care doctors are monitored for both over-utilization and under-utilization of specialty services.

The management of HMO of Pa. is enlightened, knowledgeable, and flexible. This, and an active and informed Board of Directors, have helped the plan avoid many serious problems.

II. HISTORY AND BACKGROUND

HMO of Pa., as presently operating, was incorporated in January, 1975. The plan's predecessor was Family Medical Care, Inc. (FMC), an IPA-like organization.

In 1972, R.H. Medical Services, Inc., a publicly held proprietary hospital company, incorporated Family Medical Care, Inc., as a wholly owned subsidiary. The corporate purpose of FMC was to develop a neighborhood-oriented, integrated system of total health care. This was to be accomplished by means of a network of contracting primary care physicians. The system was also designed to include participating specialists. Inpatient services were to be provided through contractual arrangements. A second subsidiary, Family Medical Care Insurance Company (FMCI), was formed to act as the insurance arm of FMC.

The basic structure of FMC was based on the IPA model as defined in the recently enacted PL 93-222 (12/73) which became Title XIII of the Public Health Service Act. Thus, FMC and FMCI formed the basic foundation upon which the HMO has been built.

FMC began operations in early 1974 at about the same time a non-profit organization was formed to study the feasibility of developing an IPA that would meet the requirements for federal qualification. The organization received a feasibility grant award and subsequently received planning and initial development grants. Grant awards to HMO of Pa. by DHHS total $815,016.

The plan started enrolling members and providing services in

April 1977 and was qualified under Title XIII of the Public Health Service Act. Also, in June 1977, HMO of Pa. was awarded a federal loan of $2.5 million.

HMO of Pa. acquired the assets of FMC by the execution of a note payable for $525,000. This included the approximately 1,200 members enrolled in FMC and FMC's contracts with the R.H. Medical Service hospitals. The loan was later reduced to $375,000 in return for early repayment.

In addition to the assets transferred to HMO of Pa., certain personnel also shifted to HMO of Pa. Leonard Abramson was Executive Director of FMC and Vice President of R.H. Medical Services. He continues as President of HMO of Pa.

The organizational structure of HMO of Pa. is traditional, but the plan has other attributes not typically found in IPA/HMOs. Besides the unique payment mechanism, one unusual characteristic is that of the approximately 1,000 physicians who participate in HMO of Pa., about one-half are Doctors of Osteopathy, with the remaining being M.Ds. The large proportion of osteopaths is typical of medical care in the Philadelphia area, but not typical of most communities in the United States.

III. ADMINISTRATION

The structure of HMO of Pa. is similar to that of a typical industrial corporation. The organization's span of control does not exceed five persons, who have specific staff and line functional authority. The decision-making processes allow each functional area, e.g., marketing, claims, etc., to contribute to a formal decision. At the top of the organization is the Board of Directors, comprised of 11 individuals with various backgrounds: banking, business, labor, legal, management, medical and subscriber. The Board of Directors approves all policy and establishes a hierarchy responsible for the administrative responsibilities delegated to the President.

The President of HMO of Pa. functions as chief executive officer reporting to the Board and is responsible for total operations of day-to-day management. The seven associate Medical Directors assume a staff position and are responsible for the liaison with the IPA. Secondly, there are Vice Presidents in charge of Marketing, MIS, and Claims. A Vice President of Finance is to be named, but at the present time a Treasurer and two Assistant Treasurers are in charge of all reporting and financial functions.

The main responsibilities of the president of the organization are:

1. Overall liaison with the IPA.
2. All financial and administrative duties.
3. Long-term planning (usually five years).

4. Preparation of a yearly budget. This financial instrument is approved by the Board, and all performance of the Plan is measured against it. The budget includes enrollment projections, medical cost projections, capital expenditures, staffing projections, GNA projections, etc.
5. Utilizing consultant and handling all relationships with regulatory agencies, i.e., DHHS, HCFA, insurance departments, health departments.
6. Attending all IPA meetings as an ex-officio member.

HMO of Pa.'s executive staff is composed of department heads who are responsible for day-to-day operations and the budget under their span of control. The plan employs approximately 60 full-time and part-time staff.

The IPA and HMO act as one unified organization. Contact between the two components is maintained by close supervision of output surveys and comparative analysis of all statistical data.

The management information system (MIS) is designed and implemented in-house by management. The system is constantly upgraded and refined. Marketing is completely computerized and monthly activity is coordinated with an operations plan. Claims management is performed with a shift and a half maintaining 90 percent payment within 45 days. Claims are also "on line."

IV. MARKETING

HMO of Pa. serves a five-county area in the Philadelphia SMSA. The area is comprised of a mix of urban (Philadelphia proper) and suburban bedroom communities. This area is heavily industrialized, but there is no dominant employer or industry. A high percentage of the workers in Philadelphia are covered by collective bargaining agreements, but less than 2% of the Plan's enrollees are covered by such agreements.

The currently enrolled population tends to be well educated and in the mid- to upper-income categories. Approximately 85% of the enrollees are under age 40.

There is a general awareness of the HMO concept in the service area. Three other HMOs are currently marketing their services to similar populations: Health Service Plan of Pennsylvania and Philadelphia Health Plan, which are group models, as well as the Greater Delaware Valley Health Plan, which is an IPA-model HMO. All of these plans are federally qualified.

HMO of Pa.'s original enrollment projections were 1,000 enrollees per month for the first year of operation. Past experience of DHHS, however, indicated that a more realistic projection would be about 300 enrollees per month. In actuality, HMO of Pa. exceeded DHHS's expectations and enrolled 14,000 members the first year and 15,000 members in the two subsequent years of operation. Enrollment as of June 30, 1980, was 47,664. The original market projections were developed by assembling a data base from nearby companies and

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then rating each company according to rate differential, comparison of benefits offered, employer receptivity, and accessibility of the employees to the provider sites.

The Blues are the major insurers in the area, with approximately 2.2 million subscribers. This represents about 65% of the available market. Prudential and Connecticut General also conduct strong commercial marketing efforts.

The original marketing strategy of HMO of Pa. was to concentrate on a handful of companies and to achieve heavy penetration in them. This strategy was changed quickly, after about 90 days, to one which would enable the organization to develop much broader roots. Approximately 8,500 Title XIII (Section 1310) packages were sent out to companies in the service area and were followed up by face-to-face contacts by the sales personnel.

The current marketing strategy contains the following major components:

1. In-depth and ongoing market research and analysis;
2. Continual re-evaluation and strengthing of the market strategies; and
3. Planning.

The marketing department consists of a marketing director, his assistant, and several marketing representatives. The total market area is divided into territories, each with a team consisting of a field director, a marketing representative, a member services representative, a claims representative, and a team administrator. Each target market, has a time-oriented enrollment goal. The marketing strategy

will vary for each target. Strategies are assigned in terms of their perceived cost effectiveness, which is measured directly by enrollment results. When initial strategies are not productive, alternate reserve strategies are implemented. The data from sales call reports, account data sheets and weekly sales plans are constantly analyzed to determine the proper strategy for a given entity. Those strategies that have proven effective are continued and expanded, while ineffective ones are re-evaluated or replaced by reserve strategies. The marketing representative staff is paid a base salary supplemented by incentive pay for positive results. The marketing director feels that the incentive pay is an important motivating force for the sales team.

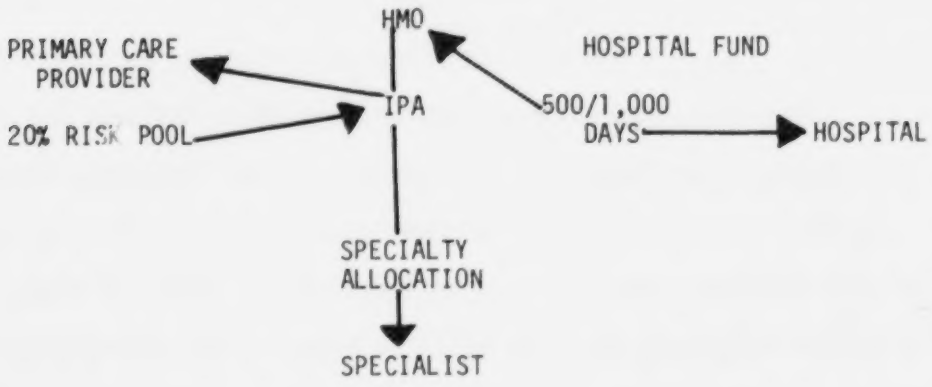
A unique and effective aid to the marketing program is the use of the computer to plan the time of the marketing staff. Each month, each staff member receives a report detailing the upcoming activities for the next several months, e.g., open season and service follow-ups due. Other reports provide activity summaries and information on each account.

In summary, HMO of Pa.'s marketing strategy is well thought out and directed rather than hit or miss. The tempered growth has enabled the plan to deal with problems associated with growth in a controlled and positive manner.

V. PROVIDER COMPONENT

Membership in the IPA is limited to primary care physicians. Specialty care is provided by contracting specialists. The primary care providers are paid on a capitation basis and must cover both their own services and specialty services on the capitation payment that they receive. The HMO calls this payment a "captainer".

Graphically, the funds flow as follows:



The specialty pool is monitored for both over- and under-utilization. The monitoring is performed to ensure that there are no abnormal patterns of utilization since the primary care physicians receive a portion of any surplus in the specialty pool. In one case, a primary care group resigned under pressure after their specialty utilization was found to be consistently below the norm.

In addition, the primary care physicians have an incentive for reducing hospital services. Presently, hospital utilization is projected as 500 patient days per 1,000 members per year. If utilization is less than 500 days, the savings are split evenly

between the HMO and the IPA. The IPA share is placed in the special IPA risk-sharing account to offset losses from any unanticipated physician costs. Should the utilization be greater than anticipated, the IPA is responsible for 50% of the losses up to the amount of uncommitted funds remaining in the special IPA risk-sharing account.

Another positive feature of this arrangement is that the primary physicians agree that the IPA may increase the percentage of the physicians' capitation payment that is retained in the risk-sharing account if the IPA deems that such an increase is necessary to ensure its financial solvency.

The contractual arrangement between HMO of Pa. and the IPA encompasses over 180 primary care physicians. The IPA considers primary care physicians to be family or general practitioners, pediatricians, and internists. A person who joins HMO of Pa. selects a primary care physician to serve as the gatekeeper for the health care network. The primary physician will orchestrate the member's complete health care needs, including emergency care, routine office visits, appropriate specialty care referral, and, if required, inpatient hospital arrangements. By having a primary or family doctor, the member can have most problems handled in the office of the main physician, and may be hospitalized less and cared for at a lower cost than the patient who self refers inappropriately to expensive specialists and utilizes the emergency room for minor ailments.

Members pay an out-of-pocket cost of a $2.00 co-payment to their primary physician which covers each office visit and medical treat-

ment. The primary physicians are reimbursed for HMO patients on a prepaid bi-monthly capitated basis. Capitation is based upon an annualized actuarial analysis of patient costs and is the same prepaid amount each month regardless of how often the patient was seen or the medical treatment given.

When specialty services are required either for outpatient or inpatient care, the primary doctor refers the enrollee to one of 1300 participating specialists. These specialists have contracted with the IPA to bill the HMO for their services and to accept its reimbursement as payment in full. Thus, a member who goes to the specialist takes along a referral slip that authorizes both the care and the payment to the specialist. The coordination and care between the primary provider and specialist is the same as for any other patient who is covered by other insurance carriers. In essence, having a primary care physician who coordinates the member's health care needs builds a "second opinion" program into the system. The member will get the first opinion from the primary physician and, if needed, can obtain a second opinion from the specialist. This eliminates the traditional seeking of multiple opinions from various specialists, which may be inappropriate and not cost effective.

As indicated above, the IPA component is made up of primary care physicians who are general internists, family practitioners, and pediatricians. The IPA has a stringent screening process, and it can often take four to six months for the application and membership process to be completed. A physician inquiring about the program speaks to either the IPA coordinator or one of the Medical Directors to

discuss the program. Then a formal written application is sent for completion by the applicant. In addition, four letters of recommendation and copies of the state license are required, along with BNND number and proof of malpractice insurance coverage. The applicant must meet 11 membership criteria which include, among other things, 24-hour-a-day coverage by a participating IPA physician, membership on the staff of a participating hospital, standards for levels of ambulatory care, and a maximum number of patients seen per hour.

Once all the letters, the documentation of coverage, and the application itself are completed, the next step is a site visit by the IPA coordinator to the applicant's office. The coordinator reviews IPA procedures and policy with the applicant and examines the physical plant. Then the applicant meets with one of the medical directors at the administrative office. Applicants bring to the interview 10 medical charts, with names deleted to ensure patient confidentiality, for a chart review with the medical director. The medical director discusses patterns of practice. Next, the application is forwarded to the general membership committee, which thoroughly reviews the application and forwards its recommendation to the executive committee of the IPA. The executive committee has the final say in recommending the applicant for acceptance or rejection.

The Quality Assurance Committee of the HMO meets bi-monthly. Among its many functions, it monitors grievances, referral utilization patterns, patient outcome surveys, patient transfers, and additional medical care evaluation studies as they relate to the primary physician offices. Currently, the Quality Assurance Committee is in the process of re-

certifying each center in the IPA for continuing cooperation, availability of coverage, response to grievance procedure, and accountability of medical care. Analysis of all this data is reviewed and it is then determined whether further study of various physicians or centers is to be done. If the Quality Assurance Committee finds a significant problem relating to the physician and his office, it is referred to the Peer Review Committee of the IPA. This Committee reviews the data submitted by the Quality Assurance Committee in order to formulate standards for quality of care. According to the IPA by-laws, this committee may meet with a primary care or specialty physician for any problem relating to the rendering of medical services. If the specific matter before the Peer Review Committee is not resolved to the mutual satisfaction of both the Committee and the physician, the matter is referred to the Executive Committee. The Peer Review Committee can make recommendations that are forwarded to the Executive Committee. These include suspension, limiting the member enrollment of the primary physician's office, holding back of payment of financial incentives, and expulsion from the IPA. The Executive Committee can suspend or expel a physician after due process has been completed.

When a grievance is registered against a physician, a formal written reply is requested from the subscriber, describing the nature of the grievance. This grievance is then reviewed by one of the medical directors and a copy of the grievance is then mailed to the physician. The response from the physician, along with the grievance, is then re-reviewed by the medical director. If it is solvable at that

level and appropriate action has been taken, regarding the nature of the grievance, the subscriber is informed of this process. If it is not solvable, or the subscriber is not satisfied with the action taken, the entire Quality Assurance Committee reviews the circumstances. If the particular grievance can not be resolved at the Quality Assurance level, it becomes a formal grievance leveled against the particular physician; the matter is referred to the Peer Review Committee and ultimately to the Executive Committee for final action.

The IPA physician committees consist of the Primary Care, Secondary Provider, Peer Review, Membership, and Executive Committees. The chairman and members of these committees are appointed by the president of the IPA on a rotational basis for one year. Physicians are required to participate actively, but many of them volunteer to participate. The only committee in the IPA that is elected by the general membership is the Executive Committee. Presently, 12 members sit on the Executive Committee of the IPA, and hold one of six one-year terms, three two-year terms, or three three-year terms.

HMO of Pa. uses IPA physicians as part-time Medical Directors. Currently, the plan employs seven part-time Medical Directors rather than one full-time Medical Director. The activities of these associate Medical Directors are regulated by the IPA coordinator. They participate on the Quality Assurance Committee, which reviews computer data and develops MCE studies regarding hospitalizations or specialty referral patterns, medical complaints, and monitoring primary physician offices. In addition to acting as a liaison between the HMO and the IPA, they also implement policy decisions,

perform membership evaluations, conduct site visits to participating offices, and undertake quality assurance analysis and long-range planning of data management. Along with this they also participate with the claims department in reviewing claims, work with the hospital coordinator regarding hospital admissions, and assist in designing and implementing methods for utilization of data. The Medical Directors are accessible to any IPA physician to answer questions regarding IPA procedures or policy. Since the Medical Directors themselves are treating patients in the community and working within the HMO system, they contribute innovative ideas and work well with the other IPA physicians.

The HMO Utilization Control System requires pre-certification of elective admissions for verification from all participating physicians. The pre-certification program requires that all elective admissions be admitted on Sunday to Thursday only and that certain lab work be completed prior to admission. The hospital coordinator receives information regarding admissions and length of stay. HMO of Pa. maintains a large utilization board that displays all HMO admissions with the initials of the patient, the diagnosis, the admitting physician, the expected length of stay, and the actual hospital stay to date.

This board is reviewed daily by the hospital coordinator and one of the Medical Directors. The patient's primary physician is sent a letter which indicates whether or not the admission was an emergency and specifies the approved length of stay. The physician is also notified when the length of stay is deviated from; in such cases,

the physician becomes involved either in the direct care of the patient or with the participating specialist. When emergency cases are treated in out-of-area or non-participating hospitals, the admissions are reviewed by the Utilization Coordinator and the Medical Directors in an attempt to transfer the patient, if possible, to a participating hospital. Furthermore, the Quality Assurance Committee reviews utilization patterns, and initiates further studies if physician or hospital utilization patterns deviate significantly from the norm. These studies are sent to the Executive Director of the HMO as well as the Executive Committee of the IPA for further consideration.

The Quality Assurance Committee consists of the seven part-time Medical Directors, the IPA Coordinator, and two R.Ns. The main purpose of this committee is to constantly review standards and establish guidelines for assuring availability, accessibility, and accountability for the continuity of health services to HMO of Pa. subscribers. This committee meets bi-monthly and reviews all computer data, monitors the various IPA primary physician offices, and establishes additional MCE Studies regarding over- and under-utilization of medical services.

VI. FINANCE

HMO of Pa.'s operations since qualification have been funded principally through premiums from subscribers, supplemented with income from investments. When operating expenses exceeded revenues, the deficit was covered by the operating assistance loan. A statement of operations from 1976 to 1979 with the budget for 1980 is attached as Schedule I.

HMO of Pa. reached an operating breakeven in November 1979, almost one year ahead of the projected time, after which point revenues have equalled or exceed expenses. At the time breakeven was achieved, HMO of Pa. incurred accumulated losses of $2,405,000.

As can be seen from the financial summary presented on a per-member-per-month basis in Schedule II, one of the key factors in HMO of Pa.'s ability to reach breakeven was the rapid enrollment of new members while containing medical and operating costs. Once the "loss ratio," or percentage of medical expense to premium revenue, could be brought to the 85% to 90% range and premium levels reached an appropriate stage, the balance could be retained to cover administrative and marketing expenses. To the extent that these later costs were semi-fixed, increasing enrollment and premium rates guaranteed that the costs would ultimately be covered and produce an operating surplus.

During the first six months of 1980, HMO of Pa. has moderately exceeded its budget with respect to enrollment and revenues and has met operating surplus projections. It appears that the budget for the remainder of the year will meet if not exceed projections.

VII. CONCLUSION

HMO of Pa., utilizing a reimbursement mechanism that was unique at the time it was implemented, has combined that payment method with strong management practices to become a successful IPA/HMO. Many times, rapid HMO growth can be the harbinger of rapidly developing financial problems, but HMO of Pa. has controlled its utilization and has met or exceeded its financial projections.

HMO of Pa.'s ability to adjust its strategies quickly is, to a significant degree, responsible for the dramatic climb in enrollment. The flexibility, combined with a highly structured marketing strategy has ensured that enrollment, while rapid, has followed a pattern that fits the utilization and cost projections. For these reasons, the example set by HMO of Pa. is a good one for other IPA/HMOs to imitate.

SCHEDULE I

HMO PA
STATEMENT OF OPERATIONS 1976 to 1979
and
OPERATING BUDGET 1980

(in Thousands of Dollars)

	Actual Operations				Budget
	1976	1977	1978	1979	1980
Revenues:					
Premium Income	$ 2	$ 401	$ 3,389	$ 9,733	$ 17,487
Investment and Other Income		23	75	169	170
Federal Grants and Private Donations	458	415			
Total Revenues	460	839	3,464	9,902	17,657
Expenses:					
Medical Claims and Capitation Costs	$ 6	$ 426	$ 3,081	$ 8,439	$ 15,237
Administrative and Marketing Costs	454	1,304	1,244	1,814	2,133
Interest Costs		54	138	205	205
Total Expenses	460	1,784	4,463	10,458	17,575
Operating Surplus (deficit)	- 0 -	(945)	(999)	(556)	82
Extraordinary Gain			139		
Net Surplus (deficit)	$- 0 -	$ (945)	$ (860)	$ (556)	$ 82
Loss Ratio	N/A	106%	91%	87%	87%
Enrollment at end of year	Nil	4,012	18,322	37,420	54,600

SCHEDULE II

HMO PA
OPERATING STATISTICS PER MEMBER PER MONTH
ACTUAL OPERATIONS 1977 THROUGH 1979
and
BUDGET 1980

	1977	1978	1979	Budget 1980
Premium Income	$ 19.39	$ 24.21	$ 27.14	$ 30.73
Less Medical Claims and Capitation Costs	(20.60)	(22.01)	(23.53)	(26.78)
Retention	(1.21)	2.20	3.61	3.95
Less Administrative and Marketing Costs	(63.05)	(8.89)	(5.06)	(3.75)
Less Interest Costs	(2.61)	(.99)	(.57)	(.36)
Underwriting Surplus (deficit)	(66.87)	(7.68)	(2.02)	(.16)
Investment and Ocher Income	1.11	.54	.47	.30
Operating Surplus (deficit)	(65.76)	(7.14)	(1.55)	.14
Federal Grants and Private Donations	20.07			
Extraordinary Gain		1.00		
Net Surplus (deficit)	$(45.69)	$ (6.14)	$ (1.55)	$ .14
Total Member Months	20,682	139,999	358,580	569,000

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